KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
Office of Local and Rural Health
Charitable Health Care Provider Program

REFERRAL FORM

Sample Referral Form

Localize the Referring Charitable Health Care Provider Information here, delete this line and copy form

Referral From: _____

Physical Street Address: _____

Physical Location (City) _____ (State)_____ (Zip) _____-____

Telephone #: _____ Fax#: _____

Email Address (if preferred) :_____

Patient

Name:_____ Date of birth: ___/___/___ Gender: __M _F
Last , First Middle Initial

Authorization for Release of Data

I authorize release of medical information (unless listed below) on my behalf to facilitate this referral.

Do not release_____
_____

Signature of patient, parent, or guardian: _____ Date:____/_____/ 20___

Referral Appointment to: _____

Date:_____

Time_____ **Street address**_____
Phone:

Reason for Referral: Recommendation (Use back for additional information)

Report of Initial Visit: (Use back for additional information)

Person Making Report _____

Please complete and return to the office at the top: